MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON
SECRETARY

CHRISTINE C. FERGUSON
COMMISSIONER

The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Determination of Need Program
2 Boylston Street, Boston, MA 02116
Telephone No. (617) 753-7340
Fax No. (617) 753-7349

March 16, 2004

Dear Prospective Applicant:

Enclosed is a current Determination of Need (DoN) Application Kit. The Kit has been modified to reflect changes in the DoN review process, resulting from amendments to DoN statute, the phasing out of Health Systems Agencies (HSAs) and changes in the health care environment. The Kit is to be completed for all applications.

The Determination of Need Program utilizes guidelines and/or methodologies assessing need for the following regulated services:

Acute Adult Psychiatric
Acute Inpatient Rehabilitation Services
Air Ambulance
Extracorporeal Membrane Oxygenation (ECMO)
Freestanding Ambulatory Surgery Centers (subject to clinic licensure)
Child and Adolescent Psychiatric Bed Need
Chronic Disease
Conversion of Acute Care Beds to Non-Acute Care Services (Acute Psychiatric, Long Term Care, Rehabilitation, and Substance Abuse)
Continuing Care Retirement Communities
Inpatient Substance Abuse Treatment
Invasive Cardiac Services (Open Heart Surgery and Left Ventricular Assist Devices)
Level IV Residential Care Facilities
Nursing Facility Replacement and Renovation
Magnetic Resonance Imaging
Megavoltage Radiation Therapy
Neonatal Intensive Care Units
Organ Transplantation
Positron Emission Tomography (PET)

If your project will involve any of these areas, please be sure to request the appropriate guidelines from this office. Please note that pursuant to 105 CMR 100.301 of the DoN Regulations, no application shall be accepted for filing if the guidelines in effect as of the appropriate filing day show no need.

Sincerely,

Joyce James, Director
Determination of Need Program

JJ/jj

Enclosures

MEMORANDUM

TO: Prospective Applicants for
Long Term Care Projects

FROM: Joyce James, Program Director

DATE: March 16, 2004

SUBJECT: Special Instructions for Completion of the
Determination of Need Application Kit

Long Term Care applicants should complete the entire application kit, with the following changes or additions:
(see also May 25, 1993 Determination of Need Guidelines for Nursing Facility Replacement and Renovation)

FACTOR 3 (Operational Objectives – see also May 25, 1993 Nursing Facility Replacement and Renovation Guidelines)

3.4 - Nursing Home DoN applicants should state: (1) their plans for referring applicants for admission who may be appropriate for acute care services or home care services, and (2) their plans for coordination of services with the appropriate home care corporation, including planning for residents who are appropriate candidates for discharge into the community.

NOTE: Home Care Corporations are independent corporations charged with the responsibility of carrying out the Home Care Program of the Executive Office of Elder Affairs. Each Home Care Corporation provides or arranges home care for residents in the service area of the corporation. Home care services are designed to assist elders in maintaining independent living within their home environment.

There are about 30 home care corporations in the state of Massachusetts. DoN applicants should contact the Executive Office of Elder Affairs to determine which Home Care Corporation covers the geographic area of the service area of the proposed facility. The toll-free information number at the Executive Office of Elder Affairs is 1-800-882-2003.

FACTOR 4 (Standards Compliance):

Applicants should review the general standards of construction for a long-term care facility (105 CMR 150.000) which is available at the State House Bookstore (727-2834). Also, applicants should note that the gross square feet space per bed should not exceed the DoN standard of 420 gross square feet for the entire facility.

FACTOR 5 (Reasonableness of Expenditures and Costs):

Complete schedules A, C, D, E, F, F1, F2, G, and H. Schedule H should be completed by level of care. Substitute "Level of Care" for "Service" wherever the term appears.

FACTOR 6. (Financial Feasibility and Capability)

Applicants are advised to review the Division of Health Care Finance and Policy's regulations at 114.2 CMR 6.00 to determine the actual payment to providers for MassHealth (Medicaid) residents.
Applicants should consult the DoN staff for the latest standards on cost per gross square footage, major movable equipment, and pre- and post- planning costs.

Applications associated with Life Safety Code renovations should include copies of survey reports.

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Telephone No. (617) 753-7340
Fax No. (617) 753-7349

These instructions were designed to facilitate the Determination of Need process. We hope you find them helpful. For further assistance, contact the DoN Program, Executive Office of Elder Affairs, Division of Health Care Finance and Policy, or other agencies as appropriate.

MEMORANDUM

TO: Prospective Applicants

FROM: Joyce James, Program Director

DATE: March 16, 2004

SUBJECT: Determination of Need Application Kit

The Determination of Need (DoN) Application Kit can now be found at the Department's web site www.state.ma.us/dph/dhcq/don.htm. The Kit also has been revised to reduce the amount of documentation required for completion. For example, the section on Application Narrative requires a brief Project Summary of the proposed project instead of detailed information required elsewhere in the application. The factors applied in Determination of Need have been revised to reflect updated DoN Guidelines.

This is also a reminder that copies of the completed Determination Application should be sent to Department of Mental Health and Executive Office of Elder Affairs only if the project involves, respectively, mental health services or long term care. A new web page has been added with the name and address of the contact person at each agency, division or office where an application or applications should be submitted.

MASSACHUSETTS DETERMINATION OF NEED APPLICATION KIT

Determination of Need Program
2 Boylston Street, 3rd Floor
Boston, MA 02116

INTRODUCTION

The purpose of the Massachusetts Determination of Need Application Kit is twofold. First, it is to provide applicants with a clear indication of the nature, scope and depth of preparations expected of them. Second, it is to provide DoN Program staff, as well as the Public Health Council, with the information necessary for fair, thorough and discerning evaluations. The Kit should contribute to the speed, consistency, and predictability of reviews while increasing public involvement and encouraging development of inter-institutional relationships.

It should be noted that many of the questions presented in this Kit are organized according to the "FACTORS" found in Massachusetts Determination of Need Regulation 105 CMR 100.533, FACTORS APPLIED IN DETERMINATIONS. The questions listed under individual factors in the Kit are intended to assist applicants and reviewers by gathering relevant information in a structured and convenient manner. Although questions are grouped by factors, the completed application will be viewed and evaluated in its entirety. Questions have been categorized in order to avoid unnecessary repetition of data requests rather than to limit the use of specific information to the evaluation of any particular factor of factors.

Since no general Kit can be exhaustive in its data requests, it will remain the responsibility of applicants to provide all necessary information. Currently, it is often necessary for reviewers to request applicants to supply information not supplied in their original application submission. Use of this Kit is expected to substantially reduce, although not eliminate, the need for additional data requests. Statutory and regulatory changes may take place from time to time and may not be reflected in this Kit. It is the duty of the applicant to be cognizant of such changes and to file an application consonant with such changes.

Updated March 16, 2004

GENERAL INSTRUCTIONS

Enclosed is an application form for Determination of Need. In order to complete this form, it is necessary to read and comply with the Massachusetts Determination of Need Regulations 105 CMR 100.000. The Regulations may be obtained from the State House Bookstore, Boston, MA 02133, Telephone: (617) 727-2834.

Assistance in preparing applications is available from the Determination of Need Staff as is compatible with the Staff's other duties. They may be reached at 1-617-753-7340.

CONTENTS OF APPLICATION

Please refer to Sections 100.300-100.303, APPLICATION SUBMISSION PROCESS, and to Sections 100.320-100.326, CONTENT OF APPLICATIONS, of the regulations regarding the required contents of the application.

Please note that Sections 100.350-100.354, AMENDMENT AND WITHDRAWAL, substantially limit the right of applicants to alter applications or to provide additional information after an application has been submitted. Therefore, do not file an application unless and until all important information is included.

Please note that if a filing fee is required (See Section 100.323) it must be submitted with the application, by check, payable to the "Commonwealth of Massachusetts".

Attention is directed to Section 100.306, STANDING TO MAKE APPLICATION, of the regulations, requiring documentation as to ownership and zoning. Such documentation need only be submitted with the original copy and referenced in succeeding copies.

Newspaper Notice: Every applicant for Determination of Need is required to publish a notice of application, as prescribed in Sections 100.330-100.332, NOTICE REQUIREMENTS, in the Legal Notice section of the appropriate newspaper and an identical notice at least once in some other section as well. Refer to the Regulations for details of publication. Please note that the final day to request a public hearing or to register as a ten taxpayer group (following the publication) must be on a business day. Please attach a TRUE COPY of the notices of publication with date of publication, as required under the above section, immediately after page 3 of general instructions.

No application will be accepted if the requirements of Section 100.306 and 100.320-100.326 are not met, and no application will be accepted if all relevant parts of the Application Kit are not complete.

PLEASE NOTE: The Determination of Need Application Kit asks applicants, in some cases, to supply answers on additional sheets. Where additional sheets are used, they should be clearly labeled with the factor name, question number (and page number) to which they pertain.

GENERAL INSTRUCTIONS

DISTRIBUTION OF COPIES

(Section 100.300 SUBMISSION OF APPLICATIONS) One complete original and two additional copies are to be submitted to:

Department of Public Health
Determination of Need Program
2 Boylston Street, 3rd Floor
Boston, MA 02116

Copies must also be submitted as follows (number of copies shown in parentheses):

Department of Public Health (1)
Regional Health Office
(See 100.300 for appropriate office)

Executive Office of Elder Affairs (2)
One Ashburton Place, 5th Floor

Division of Health Care Finance and Policy (1)
Two Boylston Street
Boston, MA 02116

Division of Medical Assistance (1)
600 Washington Street

Boston, MA 02108 Boston, MA 02111
(If relevant under Section 100.152)

Department of Mental Health (2)
Division of Clinical & Professional Services/
Office of Policy Development
25 Staniford Street
Boston, MA 02114
(If relevant under Section 100.153)

FILING FEE AND COMPUTATION SHEET

Every applicant, other than a government agency, filing under M.G.L. c. 111,s.25C is required to a accompany the application with a filing fee as indicated below:

MAXIMUM CAPITAL EXPENDITURE: $_____

x .0010 = $_____Filing Fee

Minimum Filing Fee is $250.00, regardless of maximum capital expenditure.

Applicant must attach a check or money order made payable to "The Commonwealth of Massachusetts" in the amount indicated above. If applicant claims an exemption from the filing fee, state here why applicant is exempt. Cite the applicable regulation.

DON APPLICATION FACE SHEET

1a. FILING DATE: _____ 1b. FILING FEE :_____

2. HSA: _____ 3. / / REGULAR or / / UNIQUE APPLICATION (Check one)

4. APPLICANT NAME:_____

5. ADDRESS:_____

6. CONTACT PERSON: (Name)_____(Title)_____

(Mailing Address): _____(Telephone)_____

7a. FACILITY NAME: _____

7b. LOCATION: _____

8. FACILITY TYPE (circle one):

1) Acute Care Hospital 2) Nursing Facility 3) Chronic Disease/Rehabilitation Hospital

4) Psychiatric Hospital 5) Substance Abuse Treatment Facility 6) Clinic/Satellite

9. TYPE OF OWNERSHIP (circle as appropriate):

1) Private non-profit 3) Public
2) Private for-profit 4) Other_____

10. BRIEF PROJECT DESCRIPTION (consistent with newspaper notice):

_____

_____

_____

11. PROJECT TYPE (circle one or more as appropriate):

A. Substantial Change in Service – The addition or expansion of or conversion to a new technology, innovative service, or freestanding ambulatory surgery by acute care or non-acute care facilities regardless of whether the expenditure minimum is exceeded; non-acute care services provided by acute care hospitals; and any increase in bed capacity by a non-acute care facility totaling more than 12 beds to the licensed bed capacity of the entire facility.

B. Substantial Capital Expenditure – Any capital expenditure that is at or exceeds the DoN expenditure minimums for acute care, non-acute care (including nursing homes) facilities and clinics.

B. Transfer of Ownership – Original licensure of acute care, non-acute care (excluding nursing facilities) or freestanding ambulatory surgery facilities.

DON APPLICATION FACE SHEET

12. BEDS INVOLVED IN THE PROJECT (check one or more as applicable):

Type		Number Licensed Beds	Number Beds Requested	Number Beds Replaced/Renovated
a)	Medical/Surgical	_____	_____	_____
b)	Obstetrics (Maternity)	_____	_____	_____
c)	Pediatrics	_____	_____	_____
d)	Neonatal Intensive Care	_____	_____	_____
e)	ICU/CCU/SICU	_____	_____	_____
f)	Acute Rehabilitation	_____	_____	_____
g)	Acute Psychiatric			
	i) adult	_____	_____	_____
	ii) adolescent	_____	_____	_____
	iii) pediatric	_____	_____	_____
h)	Chronic Disease Care	_____	_____	_____
i)	Substance Abuse			
	i) detoxification	_____	_____	_____
	ii) short-term intensive	_____	_____	_____
	rehabilitation	_____	_____	_____
j)	Nursing Facility Level II	_____	_____	_____
	Level III	_____	_____	_____
	Level IV	_____	_____	_____
k)	Other	_____	_____	_____

13. MAXIMUM CAPITAL EXPENDITURE: $_____ _____ _____
(month) (year dollars)

14. FIRST YEAR INCREMENTAL OPERATING COST:
$_____ _____ _____
(month) (year dollars)

v

AFFIDAVIT OF TRUTHFULNESS AND PROPER SUBMISSION

_____
(Name of Applicant)*

_____
(Address of Applicant, Street, City/Town and Zip Code)

hereby makes an application for a determination of need under Chapter 111 or 111B of the General Laws and the Massachusetts Determination of Need Regulations

for: _____ original licensure
_____ substantial capital expenditure
_____ substantial change in service

respecting a: _____ hospital
_____ long term care facility
_____ clinic
_____ other (specify)_____

for the development of:_____
(Name of facility and/or program)

at the following address:_____
(Street, City/Town and Zip Code)

Type of Ownership:

_____	City	_____	State
_____	County	_____	Private Nonprofit Organization

Proprietary:

_____	Individual	_____	Partnership
_____	Corporation		

with the following estimated capital expenditure (Section 100.020 of the Regulations)

$_____.

*All persons participating in Joint Venture DoN applications (e.g., applications with two or more corporations) should be aware that each person who comprises the "applicant" will have to be named on the license. In addition, any subsequent changes in ownership of any person comprising the licensee will require compliance with the relevant change of ownership procedures.

All joint venture applicants should carefully evaluate the effect these requirements will have on their future activities.

1

AFFIDAVIT OF TRUTHFULNESS AND PROPER SUBMISSION

I, the undersigned, certify that:

1. I have read the Massachusetts Determination of Need Regulations.
2. I have read this application for Determination of Need including all exhibits and attachments, and the information contained therein is accurate and true.
3. I have submitted the required copies of this application to the Determination of Need Program and to all relevant agencies (see below*) as required.
4. I have caused notices to be published as required by Sections 100.330-100.332 of the Regulations. The notices, true copies of which are enclosed, was published in the

_____on _____
(Name of Newspaper) (Date of Publication)

_____ on _____
(Name of Newspaper) (Date of Publication)

5. The applicant is, or will be, the eventual licensee of the facility.

Signed on the _____ day of _____, 20_____, under the pains and penalties of perjury.

For Corporation: _____ and _____
Chief Executive Officer Chairman of the Board

Partnership: _____
All Partners

Limited Partnership: _____
General Partner

Trust: _____
All Trustees

FORM MUST BE NOTARIZED IN THE SPACE PROVIDED BELOW:

_____
Notary Signature

Copies of this application have been submitted as follows:

Department of Public Health/ Regional Health Office (1)___	Division of Health Care Finance and Policy___ (1)
Division of Medical Assistance (1)___	Executive Office of Elder Affairs (2)*___
	Department of Mental Health (2)**___

*Only if the project relates to long term care
**Only if project relates mental health

GENERAL INSTRUCTIONSZ

List all officers, members of the board of directors, trustees, stockholders, partners, and any other individuals who have an equity or otherwise controlling interest in the application. With respect to each of these persons, please give his or her address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of, partnership or other equity interest. (Answer on additional sheet).

Have any of the individuals listed:

Ever been convicted of any felony or ever been found in violation of any local, state or federal statue, regulation, ordinance, or other law which arises from or otherwise relates to that individual's relationship to a health care facility?

For all individuals listed:

List all other health care facilities, within or without the Commonwealth in which they are officers, directors, trustees, stockholders, partners, or in which they hold an equity interest.

State whether any of these individuals presently have, or intend to have, any business relationship, including but not limited to: supply company, mortgage company, etc., with the applicant.

If the applicant is a corporation, please attach a copy of your articles of incorporation to this section of your application.

Indicate here the applicant's representative in regard to this application:

_____ _____
Name Telephone

_____ _____

Title Fax

_____

Facility/ Organization

_____

_____

_____

Address (Street, Town/City, and Zip Code)

All written and oral communications will be directed accordingly.

APPLICATION NARRATIVE
(PROJECT SUMMARY)

Please *briefly* describe the proposed project in the space indicated below. Detailed information is requested elsewhere in the application under the Factors Applied in Determination of Need. All applicants are required to provide an Application Narrative.

.

FACTORS APPLIED IN DETERMINATIONS OF NEED

Factor 1 HEALTH PLANNING PROCESS

1.1 Please provide a brief description of the annual planning process used by your institution, including the decision to undertake the proposed project. (Answer on a separate sheet)

1.2 Did you consult with other providers in the primary service area of this project about the relationship of this project to existing or planned operations at their institutions?

YES_____ NO_____

1.2a If your answer to question 1.2 was "NO", please explain below why you did not consult with other providers.

_____

_____

_____

_____

_____

_____

_____

_____

1.2b. If your answer to question 1.2 was "YES", please supply the name and titles of persons with whom you consulted and results of the consultation. Please demonstrate that the proposed service will or will not duplicate existing services in the applicable service area (use separate sheet if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Factor 1 HEALTH PLANNING PROCESS

1.3 Since a broad range of inputs is valuable in the planning of a project, applicants are encouraged to undertake a diverse consultative process. Please indicate which, if any, of the following agencies or groups you consulted in the development of this application.

Determination of Need Program (DPH) YES _____ NO _____

Date(s) _____

Contact Person(s) _____

Department of Mental Health YES _____NO _____NA_____
(for mental health projects)

Date(s) _____

Contact Person(s) _____

Executive Office of Elder Affairs YES _____ NO _____ N.A. _____
(for projects with special significance for elders)

Date(s) _____

Contact Person(s) _____

Division of Medical Assistance YES_____ NO_____ N.A. _____

Date (s) _____

Contact Person(s)_____

Other Relevant Agencies or Parties YES _____ NO _____ N.A. _____

Name (s) _____

Date(s) _____

Contact Person(s) _____

Name (s) _____

Date(s) _____

Contact Person(s) _____

Factor 2 HEALTH CARE REQUIREMENTS

2.1 How will this project affect accessibility of services for the prospective patients who are poor, medically indigent and/ or Medicaid eligible?

_____

_____

_____

_____

_____

2.2 Describe below and on additional sheet(s) your need analysis for this project including any special conditions for consideration. If your analysis is inconsistent with the relevant need methodology or criteria of Determination of Need Guidelines, please explain on the additional sheet(s) why you believe your methodology is more appropriate. Long-term care applications should show how they meet the criteria for bed replacement and/or substantial renovation of beds or the facility, consistent with the *May 25, 1993 Determination of Need Guidelines for Nursing Facility Replacement and Renovation.*

Factor 2 HEALTH CARE REQUIREMENTS

2.3: Statistical Data--Routine Inpatient Services

Complete only for those routine inpatient cost centers, as specified by the Division of Health Care Finance and Policy Uniform Reporting Manual, in which you are requesting a change.

	(1)	(2)	(3)	(4)	(5)	(6)
	Cost Center	Licensed Weighted Average Bed Capacity	Occupancy Rate	Average Length of Stay	Number of Discharges	Number of Patient Days
1	*	XXX	XXX	XXX	XXX	XXX
2	2001 Actual (A)					
3	2002 (A)					
4	2003 (A)					
5	20 (P_1)					
6	20 (P_1)					
7	20 (P_1)					
8	20 (P_1)					
9	20 (P_2)					
10	20 (P_2)					
11	20 (P_2)					
12	20 (P_2)					
13						
14						
15						
16	*	XXX	XXX	XXX	XXX	XXX
17	2001 (A)					
18	2002 (A)					
19	2003 (A)					
20	20 (P_1)					
21	20 (P_1)					
22	20 (P_1)					
23	20 (P_1)					
24	20 (P_2)					
25	20 (P_2)					
26	20 (P_2)					
27	20 (P_2)					
28						
29						
30						
31	*	XXX	XXX	XXX	XXX	XXX
32	2001 (A)					
33	2002 (A)					
34	2003 (A)					
35	20 (P_1)					
36	20 (P_1)					
37	20 (P_1)					
38	20 (P_1)					
39	20 (P_2)					
40	20 (P_2)					
41	20 (P_2)					
42	20 (P_2)					
43						

On this line state the name of the cost center

Note: P_1 assumes project is approved and P_2 assumes project is denied.

Factor 2 HEALTH CARE REQUIREMENTS

2.4: Statistical Data--Routine Inpatient Services

Complete only for those routine inpatient cost centers, as specified by the Division of Health Care Finance and Policy Uniform Reporting Manual, in which you are requesting a change.

	(1)	(2)	(3)	(4)	(5)	(6)
	Cost Center	Licensed Weighted Average Bed Capacity	Occupancy Rate	Average Length of Stay	Number of Discharges	Number of Patient Days
1	*	XXX	XXX	XXX	XXX	XXX
2	2002 Actual (A)					
3	2003 (A)					
4	2004 (A)					
5	20 (P_1)					
6	20 (P_1)					
7	20 (P_1)					
8	20 (P_1)					
9	20 (P_2)					
10	20 (P_2)					
11	20 (P_2)					
12	20 (P_2)					
13						
14						
15						
16						
17	*	XXX	XXX	XXX	XXX	XXX
18	2002 (A)					
19	2003 (A)					
20	2004 (A)					
21	20 (P_1)					
22	20 (P_1)					
23	20 (P_1)					
24	20 (P_1)					
25	20 (P_2)					
26	20 (P_2)					
27	20 (P_2)					
28	20 (P_2)					
29						
30						
31						
32						
33	*	XXX	XXX	XXX	XXX	XXX
34	2002 (A)					
35	2003 (A)					
36	2004 (P_1)					
37	20 (P_1)					
38	20 (P_1)					
39	20 (P_1)					
40	20 (P_2)					
41	20 (P_2)					
42	20 (P_2)					
43	20 (P_2)					

*On this line state the name of the cost center

Factor 2 HEALTH CARE REQUIREMENTS

2.5: Statistical Data--Major Ancillary Services

Complete only for those routine inpatient cost centers, as specified by the Division of Health Care Finance and Policy Uniform Reporting Manual, in which you are requesting a change.

	(1) Service	(2) Standard Units of Measure	
1	**Surgical Services**	*	
2	2002 Actual (A)		
3	2003 (A)		
4	2004 (A)		
5	20 (P_1)		
6	20 (P_1)		
7	20 (P_1)		
8	20 (P_1)		
9	20 (P_2)		
10	20 (P_2)		
11	20 (P_2)		
12	20 (P_2)		
13			
14			
15			
16			
17	**Radiology Diagnostic**	*	
18	2002 (A)		
19	2003 (A)		
20	2004 (A)		
21	20 (P_1)		
22	20 (P_1)		
23	20 (P_1)		
24	20 (P_1)		
25	20 (P_2)		
26	20 (P_2)		
27	20 (P_2)		
28	20 (P_2)		
29			
30			
31			
32			
33	**Laboratory**	*	
34	2002 (A)		
35	2003 (A)		
36	2004 (A)		
37	20 (P_1)		
38	20 (P_1)		
39	20 (P_1)		
40	20 (P_1)		
41	20 (P_2)		
42	20 (P_2)		
43	20 (P_2)		
44	20 (P_2)		

- On this line, column 2, state the standard unit of measure as specified by the Division of Health Care Finance and Policy *Hospital Uniform Reporting Manual*.
- Note: Use copies of this sheet as needed

Factor 3 OPERATIONAL OBJECTIVES

3.1 If this application proposes establishment of a new health service at your institution, do you have evidence of the clinical effectiveness of this new service? Please provide relevant documentation.

3.2 Briefly describe quality assurance mechanisms that will be used to assess the appropriateness of the health service proposed in this project.

3.3 Does your institution have written referral arrangements pertaining to services covered in this application with other health care providers in the primary service area of this project? (Nursing and rest homes' applicants should have an agreement with at least one acute care hospital and one home health organization).

YES _____ (Please give brief descriptions of these referral arrangements)

NO _____ (Please explain why you do not have referral arrangements)

Note: In addition to the above measures, all projects must meet the operational objectives of relevant service-specific guidelines.

Factor 4 STANDARDS COMPLIANCE

If this project involves renovation or new construction, please submit schematic line drawings for that construction.

Please consult the Determination of Need Program staff if you require guidance in completion of this section.

See “Square Footage” under DEFINITIONS, FACTOR 5.

Factor 5 REASONABLENESS OF EXPENDITURES & COSTS

Definitions

1. Capital Expenditure

   Cost of the project expressed in a dollar amount as of the filing date (i.e., assuming the project were to commence on the filing date). (See discussion in Factor 6, Schedule D.)

2. Functional Areas
   Unit of space directly related to a particular service (e.g., nursing unit, laboratory, radiology, dietary and admissions) or a space common to the operation of the entire facility (e.g., Lobby, mechanical, major circulation, exterior wall).

3. Square Footage

   Net Square Feet (NSF): The space associated with a particular department. It includes all functional space within a department; e.g., the interior of exam rooms, closets, utility rooms and waiting areas. Also, toilet rooms, walk-in refrigerators, and storage areas should be included if they are specifically for that department. It does not include allowances for internal partitions, departmental circulation, major circulation, shafts, ductways, general mechanical space and exterior walls.

   Gross Square Feet (GSF): Includes the NSF of a Department plus circulation within the department, partitions within the department, and dedicated mechanical space (e.g., pump room for a surgical suite). The GSF for a specific functional department excludes major general mechanical space, ductwork, elevator shafts, and stairwells located within the department's boundaries; these components should instead be assigned to the GSF of a nondepartmental functional area such as "Elevators and Shafts," if they are significant.

   If a department's perimeter is an interior wall, half of the thickness of the wall is allocated to the department. If the perimeter is an exterior wall, only 3 inches (i.e., half of a standard partition) of that wall's thickness is assigned to the department; the remainder belongs to the functional area "Exterior Wall."

   Using these definitions, a facility's overall GSF is the sum total of the GSF of each functional area; that is, the total of the departmental GSF figures plus the area allocated to Major Circulation and Exterior Walls (i.e., the non-departmental areas.)

4. Cost per Gross Square Footage

   In calculating the cost/GSF, the DoN Program adds construction contract, fixed equipment not in contract, site survey and soil investigation, and architectural and engineering costs and divide by the proposed gross square footage. However, the specific costs for these components should be included separately in Schedule D.

Schedule 5.1: Square Footage and Cost Per Square Footage

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
		Present Square Footage		Square Footage Involved in Project			
	Functional Areas	Net [a]	Gross [a]	New Construction Net	New Construction Gross	Renovation Net	Renovation Gross
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40	Total						

[a] See the definitions on page 13

Schedule 5.1: Square Footage and Cost per Square Footage

	(8)	(9)	(10)	(11)	(12)	(13)
	Resulting Square Footage[a]		Total Cost		Cost/Square Footage	
	Net	Gross	New Construction	Renovation	New Construction	Renovation
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
Total			$	$		

[a] Column 8 does not necessarily equal Columns 4 plus 6 or Columns 2 plus 4 plus 6; Column 9 does not necessarily equal Columns 5 plus 7 or Columns 3 plus 5 plus 7. This is because, for example, a) there may be demolition and b) department A may be reassigned to department. B.

[b] If this does not equal the sum of Lines 3,9,10 and 11 of Schedule D, please reconcile the difference (for example, do the costs include site survey and soil investigation, fixed equipment not in contract, and architectural and engineering costs which are not figured into Line 9 of Schedule D)

Schedule 5.2 PROJECT IMPLEMENTATION

6.2 Anticipated Project Schedule

Construction/ Renovation or Installation	Start Date	Completion Date
• Phase One	_____	_____
• Phase Two	_____	_____
• Phase Three	_____	_____
• Phase Four	_____	_____
Etc.		

Operations	Start Date	Reach Normal Volume
• Phase One	_____	_____
• Phase Two	_____	_____
• Phase Three	_____	_____
• Phase Four	_____	_____

Please *briefly* describe the phrases cited above:

Phase One_____

Phase Two_____

Phase Three_____

Phase Four_____

6.3 If you have not already provided a listing and description of the equipment requirements (if any) of this project please do so in the space below or on an additional sheet.

_____

_____

_____

_____

_____

6.4 Do you have any additional information, which you would like to supply concerning the reasonableness of the expenditures and costs associated with this project?

YES_____ NO_____

If "YES", please supply this information on an additional sheet or sheets.

Factor 6 FINANCIAL FEASIBILITY

LIST OF SCHEDULES FOR FACTOR SIX

SCHEDULE A:	Statement of Revenues and Expenses
*SCHEDULE B:	Statistical/Financial Data - Revenue Producing Cost Centers
SCHEDULE C:	Staffing Patterns
SCHEDULE D:	Estimated Capital Expenditure
SCHEDULE E:	Depreciation Expense
SCHEDULE F:	Proposed Funds for Estimated Capital Expenditure
SCHEDULE F1:	Features of Permanent Financing of Estimated Capital Expenditure
SCHEDULE F2:	Application of Permanent Financing Proceeds
SCHEDULE G:	Fixed Charges Covered
SCHEDULE H:	Revenue by Payer

The purpose of "Factor Six - Financial Feasibility" of the DoN Application is to: (1) collect evidence regarding the ability of the applicant to finance and support the operation of the proposed project; and (2) highlight the probable effects of the project, in cost and statistical terms.

It may be useful as a conceptual aid to think of the schedules which comprise "Factor Six- Financial Feasibility" as sorting into these categories:

1) Schedules A-C - information about the likely impact of the proposed project on operations of the applicant (institution).

2) Schedules D-G - information about the capital cost and the method of financing for the proposed project; and

3) Schedule H - information about the applicant's recent payer mix.

The schedules request the most recent annual historical data plus two sets of three-year projections for single service projects and the most recent three years historical data plus two sets of four-year projections for capital expenditure projects. "P1" is the projection of the likely future course of operations, assuming the project under consideration is approved by the Department. "P2" is the projection of the likely future course of operations, assuming the project under consideration is not approved by the Department.

The first projection year should be the first year following the last actual. The second, third, or fourth year projection should be the point in time when the project reaches normal volume.

The assumptions which you make about costs (both operating and capital), revenues, and demographic factors must be clearly explained on separate sheets of paper to be attached to Schedule A.

Factor 6 FINANCIAL FEASIBILITY

Consistency is a key to the fairness and usability of "Factor Six- Financial Feasibility". If assumptions about unit costs, occupancies, or similar items differ between P1 and P2, explain the reasons for these

differences on separate sheets. Since it is obvious that the approval or denial of this application will not alter demographic or economic trends in your area, it is expected that assumptions for P1 and P2 will be uniform for these items. This section uses Schedule A, the operating statement, to link the various other schedules together. This interlocking system will ensure that all comparisons of P1 and P2 will be made using consistent data, which fit smoothly into the broader financial situation of the applicant.

In order to obtain forecasts or financial and statistical impacts, it is necessary for us to consider the interrelationship of determination of need projects filed by an individual applicant. Therefore, if your institution has more than one DoN application pending, or expects to file additional applications within one year of the date of this application, please note the application numbers and dates of the pending applications and the nature and scope of expected applications on the "assumptions" sheet attached to Schedule A. "P1" and "P2" projections must assume approval of all pending (rather than anticipated or expected) DoN applications. For example, an institution which has one application pending consideration, by the Department, and which is now filing another application, should:

- note the first application in the assumption section of Schedule A of the new application; and
- assume approval of the first application in both the "P1" and "P2" projections of the new application.

The new application should, in effect, show the combined projections if the first application were, in fact, to be implemented on your proposed schedule.

On some schedules, hospitals are required to report financial and statistical data according to the specifications of the Division of Health Care Finance and Policy *Hospital Uniform Reporting Manual*. Of course, this requirement does not apply to non-hospital applicants.

These schedules will provide necessary information about the probable impacts of determination of need actions on individual applicants. Schedules A, G, and H should be completed for the whole institution and not only for the project's revenue producing cost center(s).

Factor 6 FINANCIAL FEASIBILITY

Notes:

1. The financial and statistical information requested in Factor Six must be submitted on the schedules provided or on copies thereof.

2. Copies of audited financial statements for the most recent year must be filed with this application.

3. Assumptions used in projecting capital and operating costs, revenues, and demographic factors must be clearly explained on a separate sheet attached to the beginning of Factor 6.

4. Statistical data and projections provided in Factor Two are important for the Factor Six data and projections. Please review both Factor Two and Factor Six carefully to ensure overall consistency between them.

5. It is permissible to round dollar amounts to the nearest thousand, as long as such rounding does not materially affect the results. If you do so, please clearly indicate this on each page on which such rounding is done.

6(a) Use constant dollars for the projection years (that is, do not include inflation). Do not restate actual dollars.

6(b) In general, use the last complete fiscal year as the basis for constant dollars (e.g., an applicant filing May 2004 with a fiscal year ending September 2004 would state project costs in 2004 dollars).

Schedule A: Statement of Revenues and Expenses

The data presented here must tie to later schedules and **should be for the entire institution and not only for the project's cost center.** Explain all variances. Should your institution have another application pending (i.e. accepted and under review by the Determination of Need Program), the projections made in these schedules must assume *approval* of all pending applications.

	(1)	(2)	(3)	(4)

		Actual 2002	Actual 2003	Actual 2004
1	Gross Patient Service Revenue*			
2	Less: Contractuals			
3	Provision for Doubtful Accounts			
4	Free Care			
5	Other (Specify)			
6	Net Patient Service Revenue			
7				
8	Other Operating Revenue*			
9				
10	Net Operating Revenue			
11				
12	Operating Expenses			
13a	Salaries, Wages* and			
	Fringe Benefits (Exclude Pension)*			
13b	Purchased Services			
14	Supplies and Other Expenses			
15	Depreciation			
16	Interest			
17	Pension			
18				
19	Total Operating Expenses*			
20				
21	Gain (Loss) from Operations			
22				
23	Total Non-operating Revenue			
24				
25	Excess of Revenues Over Expenses			
26				
27				
28				
29				
30				

Note: For a single service project, complete the most recent year actual data and for a capital expenditure project by a hospital complete the most recent three years actual data.

Schedule A: Statement of Revenues and Expenses

	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
	Assuming Project Approval				Assuming Project Denial			
	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P2)	Projection 20____(P2)	Projection 20____(P2)	Projection 20____(P2)
1								
2								
3								

4								
5								
6								
7								
8								
9								
10								
11								
12								
13a								
13b								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								

*For each of these items state on a separate and attached sheet the assumptions you made in arriving at P1 (assuming project approval, columns 5-8) and P2 (assuming project denial, columns 9-12) figures.

Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers

Complete in detail for each revenue producing cost center affected by the project. Data for revenue-producing cost centers not affected by the project should be presented in aggregate under "Other Revenue-Producing Cost Centers". Under Other it is expected that P1 and P2 will be identical. The cost centers and standard units of measure must be those required by the Division of Health Care Finance and Policy *Hospital Uniform Reporting Manual*.

	(1)	(2)	(3)	(4)
	Cost Center	Standard Unit of	Gross Patient Service	Major Movable Equipment

		Measure	Revenue	Depreciation
	a	b		
1	2002 Actual (A)			
2	2003 (A)			
3	2004 (A)			
4	20 (P1)			
5	20 (P1)			
6	20 (P1)			
7	20 (P1)			
8	20 (P2)			
9	20 (P2)			
10	20 (P2)			
11				
12				
13	2002 (A)			
14	2003 (A)			
15	2004 (A)			
16	20 (P1)			
17	20 (P1)			
18	20 (P1)			
19	20 (P1)			
20	20 (P2)			
21	20 (P2)			
22	20 (P2)			
23	20 (P2)			
24				
25				
26	2002 Actual (A)			
27	2003 (A)			
28	2004 (A)			
29	20 (P1)			
30	20 (P1)			
31	20 (P1)			
32	20 (P1)			
33	20 (P2)			
34	20 (P2)			
35	20 (P2)			
36	20 (P2)			
37				
38				

[a] On this line state the name of the cost center (Column 1)

[b] On this line indicate the standard unit of measure (column 2) and number of units for Actual, P_1 and P_2

Note: Use copies of this sheet for additional cost centers

Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers

	(5)	(6)	(7)	(8)	(9)
	Physician Compensation & Benefits*	Direct Expenses Excluding Physician Compensation & Benefits & MME Depreciation	Total Direct Expenses (Cols. 4+5+6)	Allocated Expenses	Total Expenses (Cols. 7+8)
1					
2					

3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					

* Include in this column fringe benefits.
Note: The difference between P_1 and P_2 Schedule A, Line 19 “Total Operating Expenses” must tie to the difference between P_1 and P_2 “ Schedule B, Column 9, “Total Expenses”

Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers

	(10) Cost Center	(11) Standard Unit of Measure	(12) Gross Patient Service Revenue	(13) Major Movable Equipment Depreciation
	a	b		
1	2002 Actual (A)			
2	2003 (A)			
3	2004 (A)			

4	20 (P1)			
5	20 (P1)			
6	20 (P1)			
7	20 (P1)			
8	20 (P2)			
9	20 (P2)			
10	20 (P2)			
11	20 (P2)			
12				
13				
14	Other Revenue Producing Cost Centers			
15	2002 Actual(A)			
16	2003 (A)			
17	2004 (A)			
18	20 (P1)			
19	20 (P1)			
20	20 (P1)			
21	20 (P1)			
22	20 (P2)			
23	20 (P2)			
24	20 (P2)			
25	20 (P2)			
26				
27				
28	Total Revenue Producing Cost Centers			
29	2002 Actual (A)			
30	2003 (A)			
31	2004 (A)			
32	20 (P1)			
33	20 (P1)			
34	20 (P1)			
35	20 (P1)			
36	20 (P2)			
37	20 (P2)			
38	20 (P2)			
39	20 (P2)			
40				

[a] On this line state the name of the cost center, Column 10.
[b] On this line indicate the standard unit of measure, Column 12, and number of units for Actual, P_1 and P_2

Schedule C: Staffing Patterns

Complete in detail the staffing level of the service(s) that will be affected by the proposed project.

	(1)	(2)	(3)	(4)
		Number of FTEs*		
		2004[a] Actual Year	20_____[b] P1 Year	20_____[b] P2 Year
1	Service (specify):			
2	Personnel category			
3				
4				

5				
6				
7				
8	Service (specify):			
9	Personnel category			
10				
11				
12				
13				
14				
15	Service (specify):			
16	Personnel category			
17				
18				
19				
20				
21				
22	Service (specify):			
23	Personnel category			
24				
25				
26				
27				
28				
29	Service (specify):			
30	Personnel category			
31				
32				
33				
34				
35				
36	Service (specify):			
37	Personnel category			
38				
39				
40				
41				
42				
43	All Personnel			

*A FTE is a full-time equivalent employee. See the Division of Health Care Finance and Policy *Hospital Uniform Reporting Manual* for the computation of full-time equivalent.
[a] For the fiscal year most recently completed.
[b] The year when normal operating volume is achieved.

Schedule D: Estimated Capital Expenditure

Outlined below is a comprehensive list of all components of Estimated Capital Expenditures. Capital Expenditure as defined in the Regulations includes the site acquisition cost of land and buildings or **fair market value of land and buildings if leased (capital or operating) or donated,** the total cost of construction including all site improvements, the cost of all capital equipment or **fair market value if leased (capital or operating) or donated,** the cost of all professional fees associated with the development of the project, including fees for architectural, engineering, legal, accounting, feasibility, planning and financing services, any fee associated with financing including any bond discount, and the interest cost to be incurred on funds borrowed during construction (but not including the on-going interest expense of permanent financing).

The estimate to be computed below must be based on costs and interest rates, which assume commencement and/or implementation of the project as of the date of application; therefore, the estimate should *not* include

inflation up to the *anticipated actual* commencement and/or implementation date. (Where appropriate, an inflationary allowance is applied later during the DoN Staff's monitoring of the approved project.)

Because the inflation allowance is an iASmportant factor in large, costly construction projects, prospective applicants for such projects should consult the DoN Office for technical advice regarding completion of Schedule D. Do not include a special provision for contingency.

	(1)	(2)	(3)
	Category of Expenditure	**New Construction**	**Renovation**
1	Land Costs:	$	$
2	Land Acquisition Cost		
3	Site Survey and Soil Investigation		
4	Other Non-Depreciable Land Development [a]		
5	Total Land Costs (Lines 2 through 4)		
6	Construction Costs:		
7	Depreciable Land Development Cost [b]		
8	Building Acquisition Cost		
9	Construction Contract (including bonding cost)		
10	Fixed Equipment Not in Contract		
11	Architectural Cost (including fee, printing, supervision etc.) and Engineering Cost		
12	Pre-filing Planning and Development Costs		
13	Post-filing Planning and Development Costs		
14	Other (specify):		
15	Other (specify):		
16	Net Interest Expense During Construction [c]		
17	Major Movable Equipment		
18	Total Construction Costs (Lines 7 through 17)		
19	Financing Costs:		
20	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc.)		
21	Bond Discount		
22	Other (specify):		
23	Total Financing Costs (Lines 20 through 22)		
24	Estimated Total Capital Expenditure (Line 5 + Line 18 + Line 23)		

[a] *Examples of Other Non-Depreciable Land Development Costs*: commissions to agents for purchase of land, attorney fees related to land, demolition of old buildings, clearing and grading, streets, removal of ledge, off-site sewer and water lines, public utility charges necessary to service the land, zoning requirements, and toxic waste removal.

[b] *Examples of Depreciable Land Development Costs*: construction of parking lots, walkways and walls; on-site septic systems; on-site water and sewer lines; and reasonable and necessary landscaping.

[c] *Describe assumptions used in calculating interest rates and costs*.

Schedule E: Depreciation Expense

Complete for project's estimated capital expenditure (including the fair market value for capital lease), which will be depreciated. For a given category and cost center show in aggregate the data for assets with the same useful lives. Include in the basis the asset's appropriate share of construction interest and professional fees. Use the estimates from Schedule D.

	(1)	(2)	(3)	(4)
	Description of Asset	Basis for Depreciation	Useful Life	Annual Depreciation Expense
1	Building:			

2				
3				
4				
5				
6				
7	Land Improvements:			
8				
9				
10				
11				
12				
13	Building Improvements:			
14				
15				
16				
17				
18				
19	Parking Facilities:			
20				
21				
22				
23				
24				
25	Fixed Equipment:			
26				
27				
28				
29				
30				
31	Major Movable Equipment:			
32				
33				
34				
35				
36				
37	Total			

Note: For simplicity assume first year of depreciation is a full year depreciation not one half year of depreciation. Also, if project is to be gradually phased in do not adjust for such phasing unless it significantly affects this Schedule. Explain such adjustments.

Schedule F: Proposed Funds for Estimated Capital Expenditure

Show only those funds, which are intended to finance the estimated capital expenditure.

	(1)	(2)
	Funds Available as of Application Filing Date:	
1	Plant Replacement and Expansion Fund	$
2	Unrestricted Fund	
3	Endowment Fund	
4	Specific Purpose Fund	
5	Other (specify):	

6	Subtotal	
	Funds to be Generated/Raised:	
	Internal Sources:	
7	Accumulated Gain from Operations	
8	Accumulated Non-operating Revenue [a]	
	External Sources:	
9	Long Term Debt Proceeds [b] (available _____ /_____) [c] month year	
10	Grants (available _____ /_____) month year	
11	Unrestricted Gifts/ Bequests (available _____ /_____) month year	
12	Plant Fund Drive (available _____ /_____) month year	
13	Capital Lease (terms) _____/_____ rate years	
14	Subtotal	
15	**Total Funds** (Line 6 - Line 13)	$

[a] Exclude unrestricted gifts and bequests. Show these on Line 11.
[b] Complete Schedule F1.
[c] Provide date when total amount will be available.

Schedule F1: Features of Permanent Financing of Estimated Capital Expenditure [a]

---

1. a) Loan principal _____b) Interest rate_____ c) Term _____ yrs.

2. Does the proposed debt service require even periodic payments, which include interest and principal?
   [ ] Yes [ ] No

   If *No*, attach a separate sheet outlining the required schedule of payments of interest and principal over the term of the loan.

3. Check anticipated source of permanent financing.[b]
   [ ] Lending Institution (specify)_____

[ ] Massachusetts Health and Educational Facilities Authority
[ ] Federal Housing and Urban Development Administration Insured Mortgage
[ ] Public or Private Sale Bonds
[ ] Other (specify) _____

4. Check anticipated debt instrument.
[ ] Mortgage
[ ] Mortgage Bonds
[ ] Notes
[ ] Taxable Bonds
[ ] Tax-exempt Bonds
[ ] Bond Anticipation Note
[ ] Other (specify) _____

5. Specify the loan covenants (such as required sinking fund payments, and compensating balances) associated with the proposed financing.

_____
_____
_____
_____

6. Indicate specific extent of mortgagee's proposed collateral interest in real property, gross receipts, etc.

_____
_____
_____
_____

7. Will the proposed long term loan refinance a construction loan? [ ] Yes [ ] No

8. If *Yes,* complete the following:
a) Source of construction loan_____
b) Maximum principal outstanding_____
c) Terms of interest rate_____

9. Anticipated date for the delivery of the long-term loan proceeds_____

[a] If appropriate complete for internal as well as external loans.
[b] If uncertain, use "1", "2", etc. to indicate order of likelihood. Explain effect on cost in going from source number 1 to source number 2, etc.
Complete question 8 only if the project includes refinancing of existing debt

Schedule F2: Application of Permanent Financing Proceeds

Complete only for the estimated capital expenditures of projects requiring debt financing.

	(1)	(2)
1	Total Estimated Land and Construction Costs (from Schedule D, Columns 2 and 3, Line 5 + Line 18)	$
2	Debt Service Fund Requirement	
3	Total Financing Costs (from Schedule D, Columns 2 and 3, Line 23)	
4	Refinancing of Existing Debt	
5	Other (specify):	
6	Other (specify):	

7	Subtotal	
8	Less:	
9	Project Costs met by Internal Sources (from Schedule F, Column 2, Lines 6 + 7 + 8)	
10	Interest Income Earned During Construction	
11	Premium on Sale of Bonds	
12	Project Costs Met by External Sources Other than Debt (from Schedule F, Column 2, Lines 10 + 11 + 12)	
13	Total Deductions (Lines 9+10 + 11 + 12)	
14	Loan Principal Required (Line 7 - Line 13)	$

Schedule G: Fixed Charges Covered

Complete for the entire institution if the estimated capital expenditure for the project requires debt financing, including capital lease.

	(1)	(2)	(3)	(4)
		Actual 2002	Actual 2003	Actual 2004
1	Gain (Loss) from Operations [a]			
2	Add: Interest Expense [a]			
3	Depreciation Expense [a]			
4	Lease Payments			
5	Cash from Operations Available for Debt Service (Lines 1 + 2 + 3 + 4)			

6	Debt Service Required:			
7	Interest on Long Term Debt (LTD)			
8	Interest on Certain Short Term Debt [b]			
9	Principal Payments – LTD			
10	Reduction in Short Term Debt [b]			
11	Lease Payments			
12	Net Sinking Fund Payment [c]			
13	Total Debt Service Required (Lines 7 + 8 + 9 + 10 + 11 + 12)			
14	Ratio: Fixed Charges Covered (Line 5 ÷ Line 13)			

[a] Must tie to Schedule A data. Explain any variances.
[b] Include only short-term debt that will be rolled over or refinanced with long-term debt and any interest expense on interfund loans.
[c] Required payment to sinking fund less payment from sinking fund.

Schedule G: Fixed Charges Covered

Complete for the entire institution if the estimated capital expenditures for the project requires debt financing, including capital lease.

	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
	Assuming Project Approval				Assuming Project Denial			
	Projection 20___(P1)	Projection 20___(P1)	Projection 20____(P1)	Projection 20____(P1)	Projection 20___(P2)	Projection 20___(P2)	Projection 20___(P2)	Projection 20___(P2)
1								
2								
3								
4								
5								
6								
7								

8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								

Schedule H: Revenue by Payer

Complete for the entire institution and not only for the project actual for the two fiscal years most recently completed and projected for first full year of operation.

	(1)	(2)	(3)	(4)
		Routine Inpatient		
	Payer	Total Patient Days	Gross Patient Service Revenue	Net Patient Service Revenue
1	2003 Actual (A)			
2	Blue Cross			
3	Medicare			
4	Medicaid			
5	Other Government			
6	Worker's Compensation			
7	Self Pay			
8	Managed Care			
9	Uncompensated Care[a]			
10	Commercial			
11	Other			
12	Total			
13	2004 Actual (A)			

14	Blue Cross			
15	Medicare			
16	Medicaid			
17	Other Government			
18	Worker's Compensation			
19	Self Pay			
20	Managed Care			
21	Uncompensated Care[a]			
22	Commercial			
23	Other			
24	Total			
25	20_____ Projections (P1)			
26	Blue Cross			
27	Medicare			
28	Medicaid			
29	Other Government			
30	Worker's Compensation			
31	Self Pay			
32	Managed Care			
33	Uncompensated Care[a]			
34	Commercial			
35	Other			
36	Total			
37	20_____ Projections (P2)			
38	Blue Cross			
39	Medicare			
40	Medicaid			
41	Other Government			
42	Worker's Compensation			
43	Self Pay			
44	Managed Care			
45	Uncompensated Care[a]			
46	Commercial			
47	Other			
48	Total			

[a] Includes free care

Factor 7 RELATIVE MERIT

7.1 Please describe below and on additional sheet (if necessary) any alternatives which you have considered in the development of this project. Please also give your reasons for rejecting these alternatives.

Factor 8 ENVIRONMENTAL IMPACT

The Massachusetts Environmental Protection Act (MEPA G.L. c. 30 ss 61, 62-62H. 301 CMR 11.00 et seq.) program is an interdisciplinary program, which examines environmental impacts of state actions. Generally an entity seeking a state permit, approval or funding may be subject to MEPA review. The issuance of a Determination of Need is a state action subject to MEPA. MEPA regulations, which appear at 301 CMR 11.00, require environmental review of all DoN applications for projects exceeding the review thresholds set forth at 301 CMR 11.03. Applicants should fill out the attached checklist to determine whether MEPA Review will be required.

Projects which are reviewed must circulate and file an Environmental Notification Form (ENF). A 20-day comment period ensues from publication of the ENF in the MEPA *Monitor* (appears bi-weekly). The proposal and site plans are reviewed, and within a total of 30 days from publication, a decision will be made on whether an environmental impact report (EIR) is required.

If an EIR is required, a “scope” will be issued, identifying issues, which the EIR must address. Draft and Final EIR’s each go through 37-day review and comment periods.

Certain projects, above specified size thresholds (301 CMR 11.03), require a mandatory EIR. The MEPA regulations allow the Secretary of Environmental Affairs to waive a mandatory EIR, or to allow a

single EIR, following review of an expanded ENF. See 301 CMR 11.05(7), 11.06(8) and 11.11, and consult with the MEPA Office to discuss whether this approach would be appropriate.

Please address all inquiries to:

MEPA Office
Executive Office of Environmental Affairs
100 Cambridge Street, 20th Floor
Boston, MA 02202
Tel: (617) 727-9800

Please consult the MEPA office to determine if an Environmental Notification Form must be filed for the project. Please note that final approval of architectural plans and specifications for the project is contingent upon compliance with MEPA regulations.

FACTOR 9 COMMUNITY HEALTH SERVICE INITIATIVES

1.1 Primary and Preventive Health Care Services and Community Contributions. For all projects other than long term care projects, the applicant shall:

(a) expend over, a five-year period (or other period approved by the Department) an amount reasonably related to the cost of the project, for the provision of primary and preventive health care services for underserved populations in the project's service area (or other area approved by the Department) and reasonably related to the project, in accordance with a plan submitted as part of the application process (see 105 CMR 100.533(B) (9)), and approved by the Department; and

(b) file reports with the Program Director detailing compliance with its approved plan and, to the extent practicable, an evaluation of the health effects thereof. The frequency, content and format of such reports shall be established by the applicant, subject to the approval of the Program Director.

1.2 The plan for provision of primary and preventive health services shall be developed in consultation with the Community Health Network Areas (CHNAs) and Department of Public Health's Office of Healthy Communities to identify health issues in the service areas and the community initiatives that should be directed toward them. To identify the CHNAs in your service areas please contact the Determination of Need office.

MEPA REVIEW THRESHOLDS

The following checklist summarizes the review thresholds in the state regulations, 301 CMR11.00, which are most likely to affect health care or long-term care project. The proponent must fill out every line in the checklist, relying upon its architect, engineers, or other technical consultants, as appropriate. For potential impacts upon rare species, the proponent should refer to the Natural Heritage Atlas and consult with the Natural Heritage and Endangered Species Program of the Division of Fisheries and Wildlife (1 Rabbit Hill Road, Westboro, MA 01581). Similarly, for potential impacts upon historic or archaeological resources, the proponent should refer to the State Register of Historic Places and the Inventory of Historical and Archaeological Resources of the Commonwealth and consult with the Massachusetts Historical Commission (220 Morrissey Boulevard, Boston, MA 02125). If the proponent is uncertain as to the requirement of MEPA review, one should refer to the full MEPA regulations and consult the MEPA Office (telephone: 617/727-5830). If necessary, the MEPA Office will issue a written advisory opinion as to whether MEPA review is required. A copy of the completed checklist should be enclosed with any request for an advisory opinion.

If any line of the checklist is answered "yes," MEPA review of the project will be required. Refer to the MEPA regulations and consult with the MEPA Office for the requirements governing the filing of an Environmental Notification Form.

Threshold		Yes	No
Land	Direct alteration of 25 or more acres of land.		
	2. Creation of five or more acres of impervious area.		
	3. Conversion of land held for natural resources purposes in accordance with Article 97 of the Massachusetts Constitution to any purpose not in accordance with Article 97.		

	4. Conversion of land in active agricultural use to non-agricultural use, provided the land includes soils classified as prime, state-important or unique by the United States Department of Agriculture.		
	5. Release of an interest in land held for conservation, preservation or agricultural or watershed preservation purposes.		
	6. Approval in accordance with M.G.L. c.121B of a New urban renewal plan or a major modification of an existing urban renewal plan.		
Rare Species	1. Alteration of designated significant habitat.		
	2. Taking of an endangered or threatened species of a special concern, provided that the Project site is two or more acres and includes an area mapped as a Priority Site of Rare Species Habitats and Exemplary Natural Communities.		
Wetlands, Waterways and Tidelands	1. Provided that a Permit is required, alteration of 5000 or more sf of bordering or isolated vegetated wetlands;		
	2. Provided that a Permit is required, new fill or structure or Expansion of existing fill or structure, except a pile-supported structure, in a velocity zone or regulatory floodway.		
	3. Provided that a Permit is required, alteration of ½ or more acres of any other wetlands.		
	4. Provided that a Chapter 91 license is required, New or existing non-water dependent use of waterways or tidelands.		
Water	1. New withdrawal or Expansion in withdrawal of 100,000 or more gdp from a water source that requires New construction for the withdrawal.		
	2. Alteration requiring a variance in accordance with the Watershed Protection Act.		

Transportation	1. Construction, widening or maintenance of a roadway or its right-of-way that will: a. alter the bank or terrain located ten or more feet from the existing roadway for one-half or more miles, unless necessary to install a structure or equipment; b. cut five or more living public shade trees of 14 or more inches in diameter at breast height; or c. eliminate 300 or more feet of stone wall		
	2. Abandonment of a substantially intact rail or rapid transit right-of-way.		
	3. Generation of 2,000 or more New adt on roadways providing access to a single location.		
	4. Generation of 1,000 or more New adt on roadways providing access to a single location and construction of 150 or more New parking spaces at a single location.		
	5. Construction of 300 or more New parking spaces at a single location.		

Historical And Archaeological Resources	1. Unless a Project is subject to a Determination of Need Adverse Effect by the Massachusetts Historical Commission or is consistent with a Memorandum of Agreement with the Massachusetts Historical Commission that has been the subject of public notice and comment: a. demolition of all or any exterior part of any Historic Structure listed in or located in any Historic District listed in the State Register of Historic Places or the Inventory of Historic and Archaeological Assets of the Commonwealth; or b. destruction of all or any part of any Archaeological Site listed in the State Register of Historic Places or the Inventory of Historic and Archaeological Assets of the Commonwealth.		
ACECs	1. Any Project within a designated ACEC		

Name of Project:_____

Name of Proponent:_____

Signature:_____

Date:_____

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